CHANGING LIVES CHANGING COMMUNITIES

Through Primary Health Care

U.S. Department of Health and Human Services
HRSA BPHC Bureau of Primary Health Care
Health Resources and Services Administration

CONTENTS

CHANGING LIVES
CHANGING COMMUNITIES

Through Primary Health Care

U.S. Department of Health and Human Services
HRSA BPHC Bureau of Primary Health Care
Health Resources and Services Administration

Published in March 2001
by the Bureau for Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services

FOREWORD

CHANGING LIVES
CHANGING COMMUNITIES

The relationship between good health and earning a living, staying in school, or parenting a child is affirmed in the lives of people we see every day—like the neighbor who gets her blood pressure under control and returns to work, or the student who is doing better in school, now that his dyslexia has been diagnosed.

Health care doesn't change just one person's life. It changes the lives of entire communities. Healthy people are able to work and to take care of their families. They start companies that provide jobs, or perhaps they teach a child to read. The ripple effect is endless.

On the day you read this report, more than 45,000 people in need—about 12 million this year—will receive health care through Bureau of Primary Health Care programs. The quality of the care will equal or surpass that provided by the medical community at large. It will be delivered by local, community-based Health Centers led by local boards of directors. Health care will be available because these communities have taken charge of their own health and found the financial foothold they need through programs that support people not reached by the greater health care system.

The programs that help them are the National Health Service Corps and grants that provide funding to community-based Health Centers: Community Health Centers; Migrant Health Centers; Health Care for the Homeless and the Homeless Children's Programs; Public Housing Primary Care Programs; and Healthy Schools, Healthy Communities, a program providing grants to School-Based Health Centers.

Each of these programs is unique, but they are united by a common principle: people deserve quality health care. They deserve it regardless of race, gender, or sexual orientation. They deserve it whether they live in the Bronx, the Mississippi Delta, or Southern California. They deserve it whether they are young or old, and regardless of their ability to pay. Quality health care is a right for everyone, not just a privilege for some.

For this reason, our vision is 100 percent access to high-quality primary and preventive care and 0 disparities in health outcomes. I hope you will join us in this quest.

Marilyn Hughes Gaston, MD
Associate Administrator for Primary Health Care
Health Resources and Services Administration

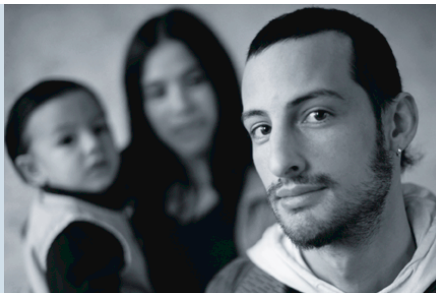
BUREAU OF PRIMARY HEALTH CARE PROGRAMS

COMMUNITY HEALTH CENTER GRANTS

In FY 2000, 699 organizations* operating nearly 3,000 sites received grants through the Community Health Center program, making it the Bureau's largest. These organizations served almost 9 million people during the year.

MIGRANT HEALTH CENTER GRANTS

More than half a million migrant and seasonal farmworkers and their families receive health care through the Bureau's oldest primary care program each year. There are 129 migrant health programs at more than 400 sites.



HEALTH CARE FOR THE HOMELESS GRANTS

The 135 organizations receiving Health Care for the Homeless grants in FY 2000 served about 500,000 people, roughly half of the 1 million Americans who lacked housing at some point during the year. Ten of the grants helped clinics provide primary health care to homeless children—the fastest growing segment of America's homeless population—through the Homeless Children's Program.

PUBLIC HOUSING PRIMARY CARE GRANTS

With the help of 26 grants, primary care services were available in FY 2000 for approximately 51,000 people who lived in some of America's most isolated communities: public housing projects. This program, started in 1992, is one of the Bureau's newest.

SCHOOL-BASED HEALTH CENTERS

Sixty-three of the nation's more than 400 school-based health centers received Healthy Schools, Healthy Communities grants in FY 2000.

*Some organizations receive grants from more than one program.

SERVING ALMOST 12 MILLION PEOPLE AT 4,000 SITES

BLACK LUNG CLINICS PROGRAM

Fifty clinics, funded through 14 grants, are providing diagnostic and treatment services in addition to outreach and health education to active and retired coal miners living with black lung disease.

NATIVE HAWAIIAN HEALTH CARE PROGRAM

Native Hawaiians encounter significant barriers to health care and suffer disparities in health status resulting from geography and culture. This unique program addresses these issues through services that facilitate access to health care and scholarships for Native Hawaiian students in the health professions.

NATIONAL HANSEN'S DISEASE PROGRAM

Recognized worldwide for achievements in treatment, rehabilitation, and training in Hansen's disease (formerly known as leprosy), the National Hansen's Disease Program continues work that began more than 100 years ago.

NATIONAL HEALTH SERVICE CORPS

This program helps communities in health professional shortage areas develop quality systems of care through community development support and the offer of recruitment and retention incentives to students and clinicians, such as scholarships, loan repayment, and service learning opportunities. Currently, more than 2,500 National Health Service Corps clinicians are treating close to 2 million patients.

Find out more at www.bphc.hrsa.gov.

"At SALUD, no one ever said to Duane, 'How could you do this?' Instead, it was, 'How can we help you?'"

CHAPTER 1. THE PEOPLE WE SERVE

CHANGING LIVES CHANGING COMMUNITIES

TWELVE YEARS AGO, I came out to the kitchen for breakfast and found my husband sitting there shaking. Duane was having a nervous breakdown. In the middle of the night he had gotten out of bed, gone outside, and tried to kill himself by walking in front of a truck. He had been working long hours branding sheep, and we were having some really hard times financially. We thought we had turned the corner; we didn't see this coming.

Our minister rode with us to the clinic, and Dr. Denegri was waiting for us when we got to SALUD. Neither SALUD nor God have left our side since. It hasn't been easy. Duane responded well to treatment for mental illness, but SALUD also uncovered borderline diabetes and severe hypertension. I never imagined when I joined the board in 1986 that my family would soon need SALUD so much.

At SALUD, no one ever said to Duane, "How could you do this?" Instead, it was "How can we help you?" Duane and I are going to do everything we can to make sure that SALUD is around for other people when they need it. And, believe me, you never know when you are going to need health care.

Many of our friends are more willing to reach out for help when they need it because of what they've seen in Duane. SALUD has had a profound impact on our daughter's life, too. She's an HIV/AIDS health educator in Reno, Nevada, and just presented a paper at a conference in Boston. I love the idea that her work is helping so many people. She got interested in health education because of the SALUD staff and the great work they do.

Now Duane and I are caretakers on a small ranch. It's a beautiful and quiet place. We take care of the animals, tend the grounds, and provide security. The owners have a few oil wells, and we help keep those going, too. Life is better for us, and much of the credit goes to SALUD and the caring people there.

Colleen and Duane Laeger, Plattesville, Colorado

CHAPTER 1

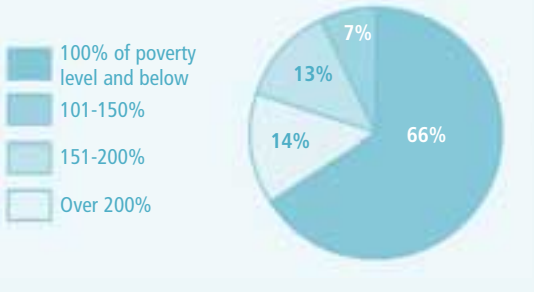
THE PEOPLE WE SERVE

Health Centers* and National Health Service Corps providers care for people not reached by the larger health care system, people working hard to build a life for themselves and their families. People like you and me, mostly, except that they do not have access to resources to meet their health care needs on their own.

MISSION STATEMENT: BUREAU OF PRIMARY HEALTH CARE

Increase access to comprehensive primary and preventive health care and improve the health status of underserved and vulnerable populations.

Poverty is pervasive among our patients.



Source: Bureau of Primary Health Care (see note 1, chapter 1).

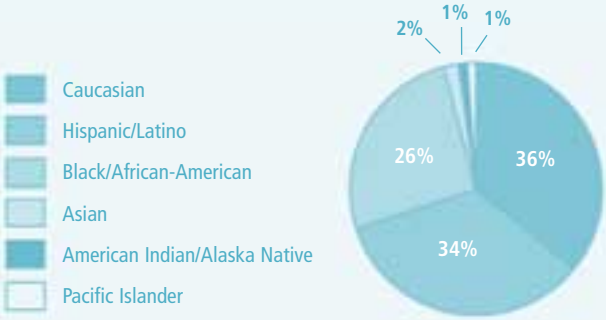
POVERTY AND HEALTH INSURANCE COVERAGE

Health Centers and National Health Service Corps sites serve almost 12 million people. Most are poor: more than 85 percent live below 200 percent of the poverty level, and 4.5 million have no health insurance. Most of the 42.6 million uninsured in America in 1999 were in working families, but they were often in low-paying jobs that offered no health insurance. Almost half of low-income workers—47.5 percent—were uninsured in 1999.[2] Most of the uninsured are under age 65, because Medicare covers virtually all seniors.

All of these individuals are welcome at Health Centers and National Health Service Corps sites because they serve people regardless of their ability to pay.

*In this report, "Health Centers" refers collectively to Community Health Centers, Migrant Health Centers, Health Care for the Homeless and Homeless Children's sites, Public Housing Primary Care Clinics, and Healthy Schools, Healthy Communities sites (School-Based Health Centers), except where noted.

Most of our patients are minorities.



Source: Bureau of Primary Health Care (see note 1, chapter 1).

RACE AND GENDER

More than two-thirds of our patients are minorities, and 59 percent are women. Many have historically lacked access to health care, not only because of poverty and inadequate health insurance, but also because of discrimination and a shortage of culturally competent providers.

AGE

Our patients are of all ages, but children 12 years old and under represent the single largest portion, at 29 percent. Twenty percent of our patients are from ages 13 to 24, 28 percent from 25 to 44, and 16 percent from 45 to 64. Just 7 percent are 65 or older.

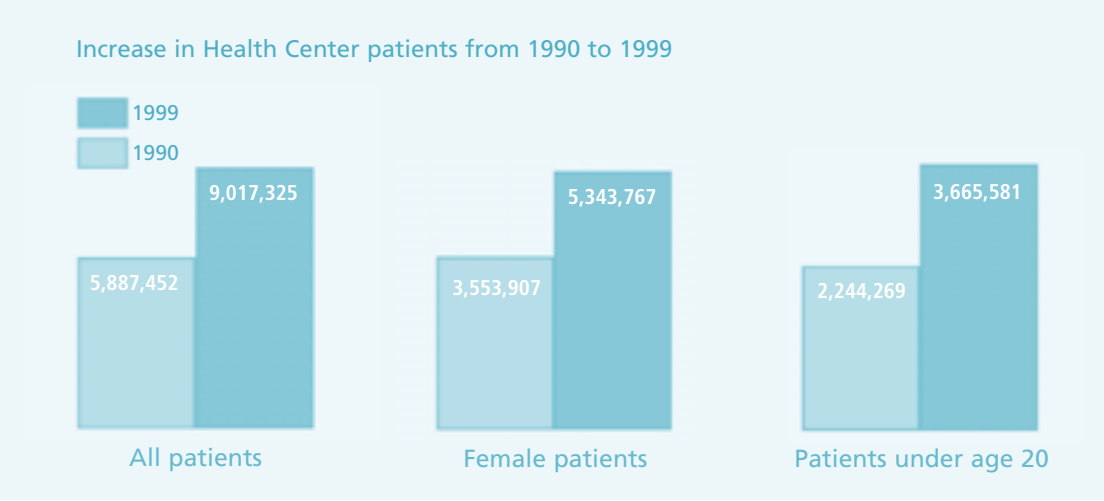
SPECIAL NEEDS

This year we will serve more than one-half million migrant and seasonal farmworkers. They often live in severe poverty and are at high risk for occupational injury: the U.S. Environmental Protection Agency estimates that 300,000 farmworkers suffer from acute pesticide poisoning each year.[3]

We reached approximately 500,000 homeless people in FY 2000—about half of the estimated 1 million Americans without housing at some point during the year. More than 90 percent of these patients lived below the Federal poverty level ($17,050 for a family of four in 2000).

Through a series of targeted programs, we are serving other segments of the population that face significant barriers to health care. More than 51,000 of our patients in FY 2000 were living in public housing—some of the nation's poorest, most isolated communities. They are receiving care from providers on the premises of their public housing complex. Our Healthy Schools, Healthy Communities Program reaches children and adolescents through School-Based Health Centers. And another special initiative targets Native Hawaiians, who suffer illness and disease at catastrophic rates.

In every case—whether for homeless children or working parents, retired mine workers or local policemen—we are providing quality primary health care that is changing lives and changing communities. With the dramatic increase in the numbers of people served, this work is more important today than ever before.



Source: Bureau of Primary Health Care (see notes 1 and 4, chapter 1).

"I love my work, but I'm still our only physician, and we still don't have enough support staff."

CHAPTER 2. QUALITY IN PRIMARY CARE

CHANGING LIVES CHANGING COMMUNITIES

SITUATED ALONG a sparsely populated Alabama coastline, Bayou La Batre Rural Health Clinic is the main source of health care for 2,500 area residents. Dr. Regina Benjamin is the clinic's only doctor.

"We have 4,400 charts, which tells me we've seen most of the people in the area at some point," says Dr. Benjamin. "Many of our patients are shrimpers and stay out on their boats for 2 or 3 weeks at a time. I can't be there to monitor their blood pressure or their response to medications, so I teach them how to take care of themselves."

A National Health Service Corps alumna, Dr. Benjamin became interested in medicine while at Xavier University in New Orleans. She never knew a black doctor when she was growing up.

"It's not that I thought I couldn't be a doctor because I'm black. It's more basic than that. The question of whether or not to be a doctor never arose, but when I decided to pursue medicine, the National Health Service Corps meant I could focus on organic chemistry instead of how to pay for medical school."

Dr. Benjamin believes that when you concentrate on taking care of people, other things fall into place—but she isn't passive about the clinic's future. She can't afford to be, because the clinic still doesn't have the money to pay her salary. To make ends meet, she moonlights in hospital emergency rooms, makes speeches, and serves as associate dean for rural health at the University of South Alabama College of Medicine. She is building a nonprofit organization that will raise funds to make Bayou La Batre viable over the long term.

"I love my work, but we've had our challenges. I'm still our only physician, and we still don't have enough support staff. Hurricane George brought 5 feet of saltwater into our clinic in 1998 and destroyed our site. It has taken 2 years to rebuild. We don't have a lot of furniture yet, but our patients don't mind."

Dr. Regina Benjamin, Bayou La Batre, Alabama

CHAPTER 2

QUALITY IN PRIMARY CARE

We believe that circumstances like poverty and inadequate health insurance do not have to lead to poor health, and for people reached through the Health Centers and the National Health Service Corps, they do not. For example:

- Health Center patients with diabetes are more than twice as likely as patients seen in private practices to be monitored appropriately.[1]
- African-Americans and Latinos are three times more likely to have their blood pressure under control if they receive care at a Health Center.[2]
- African-American newborns are much more likely than their Caucasian counterparts to suffer from low birth weight, but when their mothers receive prenatal care at Health Centers, their risk is reduced by almost one-third.[3]

These results reflect our commitment to eliminating health disparities among our patients, regardless of income, insurance coverage, race, gender, or any other characteristic.

African-American infants receiving care at Health Centers are less likely to suffer from low birth weight.

Source: Bureau of Primary Health Care (see note 3, chapter 2).

DEFINING PRIMARY CARE

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Source: Donaldson, M.S., et al., editors, *Primary Care, America's Health in a New Era.* Washington, DC, National Academy Press, 1999.

For a parent struggling to make ends meet or a breadwinner fighting to stay on the job, good health is often the difference between supporting a family and being destitute, between contributing to a community rather than just depending on it, between hope and despair. When we open the doors to quality primary care, individuals at risk are given the chance for a better life.

ELIMINATING DISPARITIES THROUGH PREVENTION

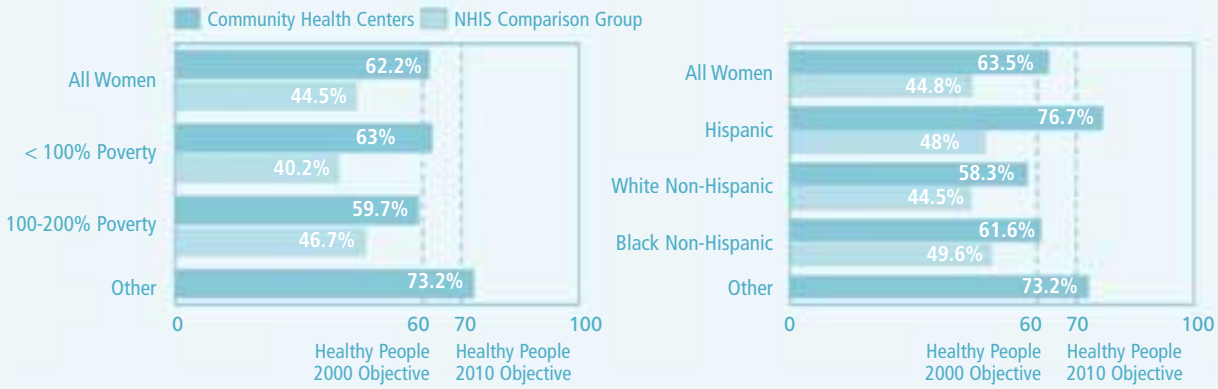
High deductibles and disallowed services often put preventive medicine out of reach, even for those with health care coverage. Health Centers see all patients, however, regardless of their ability to pay. They are committed to preventive care, and the results are reflected in patients' health. For example:

- Female patients seen at Health Centers are more likely to receive certain cancer screenings (e.g., Pap tests, mammographies, and breast exams) than are low-income women in the general population.[4]

- Immunization rates among children have improved dramatically in Health Centers. More than 200 Health Centers are participating in the Together for Tots Program, an initiative to increase immunization levels among children. At sites reporting in spring 2000, 82 percent of 2-year-olds had received standard immunizations.*

*Standard immunizations include 4 diphtheria, pertussis, and tetanus; 3 poliomyelitis; 3 Haemophilus influenzae; 3 hepatitis B; and 1 measles, mumps, and rubella.

Health Center women exceed comparison group and Healthy People objectives for up-to-date mammograms.[5, 6]



Source: National Center for Health Statistics and Bureau of Primary Health Care (see notes 5 and 6, chapter 2).

Immunizations are a health issue for adults, too. The Bureau and its partners recently launched a program to improve immunization rates among adolescents and adults for diseases like influenza and hepatitis B. Immunizations are one more way to keep patients working, taking care of their families, and out of hospital emergency rooms, where care costs more.

ELIMINATING DISPARITIES BY BEATING CHRONIC DISEASES

Chronic disease preys on the very people the Bureau serves: the poor, the uninsured, minorities, and people who live in historically underserved areas. Take diabetes, for example:

- More than 10 percent of African-Americans, Latinos, and Native Americans have diabetes, compared with 5.9 percent of the total population.
- Twenty-five percent of African-Americans between ages 65 and 74 have diabetes, as do more than 26 percent of Puerto Ricans between ages 45 and 74.
- Among one Native American tribe in Arizona, 50 percent of those between ages 30 and 64 have diabetes.[7] The Pima Indians have the highest rate of diabetes in the world.

The Institute for Healthcare Improvement defines a collaborative as an intensive effort of health care professionals making significant changes to improve clinical outcomes and reduce costs. For example,

HEALTH CENTERS IMPROVE QUALITY IN DIABETES CARE

The number of diabetes patients who had a foot exam increased from 15 percent to 67 percent in just 1 year at Clinica Campesina in Lafayette, Colorado, a participant in the first Diabetes Collaborative.

more than 200 Health Centers are part of the Diabetes Collaborative, an effort to decrease and delay the complications of diabetes, decrease the economic burden of diabetes for patients and communities, and generate and document improved health outcomes for underserved populations.

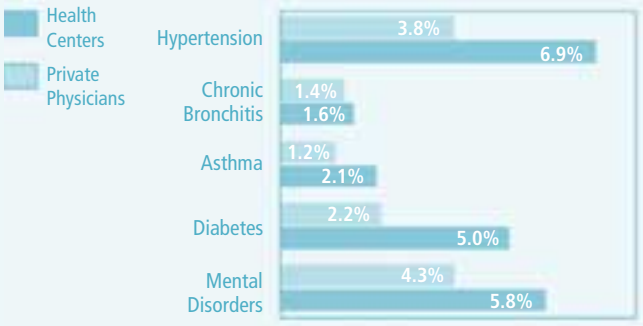
The results have been astounding. Some centers have been successful in lowering patients' hemoglobin A1c levels, a measure of glucose control. This outcome is significant, because a 1 percent reduction in hemoglobin A1c would result in a 17 percent reduction in mortality, a 15 percent reduction in stroke, and an 18 percent reduction in cataract extraction.

Patients are seeing equally striking improvements in the treatment of other diseases. Asthma affects more than 15 million people in the United States, and its prevalence rose among all age groups from 1980 to 1994. It disproportionately affects African-Americans and children and is more likely to strike females than males.[8] Even though the Asthma Collaborative began only in January 2000, improvements in health outcomes are already being reported. At one participating School-Based Health Center, the average percentage of symptom-free days for asthma sufferers over a 2-week period increased from 35 to 71 percent over a 6-month period.

ELIMINATING HEALTH DISPARITIES THROUGH QUALITY STAFF

Health Centers exist in an environment that would challenge any Fortune 500 company. Forty-one percent of Health Center patients are uninsured. Reimbursements from the insurer of 33 percent of all Health Center patients—Medicaid—often fall below the costs of providing care. Relationships that make surgery and other specialty services available to patients are threatened as more and more people in private practice take fewer and fewer indigent patients. The future of Health Centers is linked to the ability of their managers to overcome these challenges.

More Health Center visits are related to chronic conditions (as percent of total visits).



Source: The Kaiser Family Foundation (see note 7, chapter 3).

Most Health Center administrators have advanced degrees; in 1994, 63 percent held at least a master's degree and almost 1 in 10 held a doctorate.[9] One-third of the board chairs held a bachelor's degree, and 43 percent held an advanced degree.[10]

Health Center managers are creating environments where patients are more satisfied, resources are used more efficiently, and clinicians are more productive. They are building relationships with training institutes that guarantee patient access to dental care, mental and behavioral health care, and specialty services. They are using the interdisciplinary team approach to deliver community-based care and winning the support of businesses and employers who share the common goal of a healthy work force.

Primary Care Effectiveness Review

Health Centers use internal management tools to isolate challenges, identify solutions, and monitor success. The Primary Care Effectiveness Review, used by Bureau of Primary Health Care program management, can provide clinics with a mechanism for monitoring performance in four areas: mission and strategy, clinical programs, governance, and management and finance. Managers use review results to avoid problems before they occur and manage scarce resources for maximum return.

JCAHO Accreditation

The quality of management and clinical staff at Health Centers is most clearly revealed in results from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation process. JCAHO assures the community that the care received at Health Centers is of the highest quality. As of September 2000, all of the 180 community, migrant, and health care for the homeless grantees that had applied for JCAHO accreditation had received it.

HEALTH CENTERS REDUCE COSTS

California—Medicaid recipients treated at Health Centers had 27 percent lower hospital costs than those who were not treated at the centers.

New York—Medicaid recipients treated at Health Centers were up to 30 percent less costly to treat than those treated elsewhere.

Washington—Medicaid recipients treated at Health Centers required 31 percent fewer hospital emergency room visits, 44 percent fewer prescriptions, and 71 percent fewer hospital outpatient visits than those treated at other facilities.

Source: Falik, M., et al., *ACSC Experience by Usual Source of Health Care* (see note 12, chapter 2).

ELIMINATING DISPARITIES THROUGH CULTURAL COMPETENCY

Diversity in the United States provides a vast reservoir of experience and abilities that result in unsurpassed ingenuity, energy, and development. But unless people have access to care that reflects their unique values, health disparities will continue.

Our experience with providing culturally competent care is critical to a nation that is becoming more diverse. Our approach to patients reflects an understanding that culture has many components: history, politics, language, gender, socioeconomic status, sexual orientation, physical and mental capacity, age, religion, housing status, and regional differences. Cultural competency is one reason that, according to one study, 97 percent of Health Center patients report that they would recommend their center to their family and friends.[11]

REDUCING COSTS THROUGH QUALITY CARE

Replacing unnecessary hospital emergency room and other hospital visits with primary care reduces health care costs. But every year, millions of people stay away from the doctor's office for a single, simple reason: they don't have enough money. A sliding-scale fee system has resolved this problem for patients at Health Centers and National Health Service Corps sites. Our drug pricing program helps ensure access to medications.

The number of hospitalizations and emergency room visits decreases as people enter care at a Health Center. Research has shown that Health Center patients insured through Medicaid are 22 percent less likely than the general population to be hospitalized for conditions that could be treated in ambulatory care settings.[11] Studies also indicate that Health Centers treat Medicaid enrollees at a lower cost per visit than do hospital outpatient departments.[12]

"Twelve years ago, I was starting over. I was depressed, unemployed, and without support from my family."

CHAPTER 3. DEFINING OUR CHALLENGES

CHANGING LIVES CHANGING COMMUNITIES

AT FIRST, I THOUGHT I should accept my husband's abuse, because I was abused growing up. But I got a wake-up call when he hit me from behind and knocked my 18-month-old daughter, Tanya, out of my arms. My son Philip was 5 then, and Tiffany was 3.

I took my kids with me to the welfare department and sat there and cried. They put me in touch with a shelter for women, and that's where I met Kathy.

Kathy is a nurse at Health Care for the Homeless in Springfield, Massachusetts. When I met her 12 years ago, I was starting over. I was depressed, unemployed, and without support from my family. My kids, like most who grow up in families where there is abuse, were developmentally delayed.

Kathy and her colleagues helped me get on my feet. They got help for my children, and I got a medical evaluation. They also helped me get temporary housing and treatment for depression.

The support I received helped me help myself. I enrolled in a GED class. That's where I met Eric, who had also been homeless. He helped me get furniture for my new apartment, stood by me through my ups and downs, and loved my children. In 1996, 14 days after I earned my bachelor's degree in social work, I married him. We got our house 2 years later.

We're at a good place now. Eric has a job that provides health insurance. I reached a burn-out stage in social work, so I've taken a customer service job with a cable company. I love it. It's a lot like social work: you let people yell and get it all out, and then you get down to business and try to make things better. Plus, I love the computer, and this job combines working with people and working with technology.

Playing pool is our pastime. There's a pool hall here that doesn't serve alcohol where we go a couple of nights a week. As I write this story, we are playing in a tournament. Eric and I finally took our honeymoon this year, to Las Vegas.

Cindy Renselaar with daughter Tiffany
Springfield, Massachusetts

CHAPTER 3

DEFINING OUR CHALLENGES

We are mobilizing public and private resources to make sure that the question of how healthy we are is determined by disease and science, not by race or gender, income or address, or any other characteristic. Our goal is 100 percent access to health care for all Americans and 0 disparities in health status.

——Marilyn Hughes Gaston, MD
Associate Administrator for Primary Health Care
Health Resources and Services Administration

Keeping programs viable and positioned for growth requires that we navigate a health care environment fraught with difficulty. Much depends on how we deal with factors that are simultaneously increasing need and influencing our ability to meet that need. No issue looms larger than the challenge of ensuring health care for people with inadequate health insurance—or none at all.

CHALLENGE NO. 1: LACK OF HEALTH INSURANCE

In 1999, 42.6 million people had no health coverage whatsoever.[1] Millions more had insufficient coverage. Health Centers and National Health Service Corps sites currently care for about 4.5 million uninsured people—10.6 percent of the uninsured population in the United States. In all, 41 percent of Health Center patients today are uninsured, up from 38 percent in 1990.

Health insurance matters: people who are not insured are more than twice as likely as the insured to be diagnosed with late-stage melanoma.[2] Uninsured women are at least 40 percent more likely to die of breast cancer.[3] Ten million children age 18 and younger did not have health insurance in 1999.[4] Children in fair-to-poor health—those who need care the most—were four times less likely to see a physician when they were uninsured.[5] The uninsured are more likely to be hospitalized for preventable conditions[6] and more likely to receive care in hospital emergency rooms for conditions that are treatable earlier in a clinic setting—when their response to therapy would have been more positive, and the cost of care lower.[4]

More than 80% of uninsured Americans were in working households in 1998.

Source: The Kaiser Family Foundation (see note 3, chapter 3).

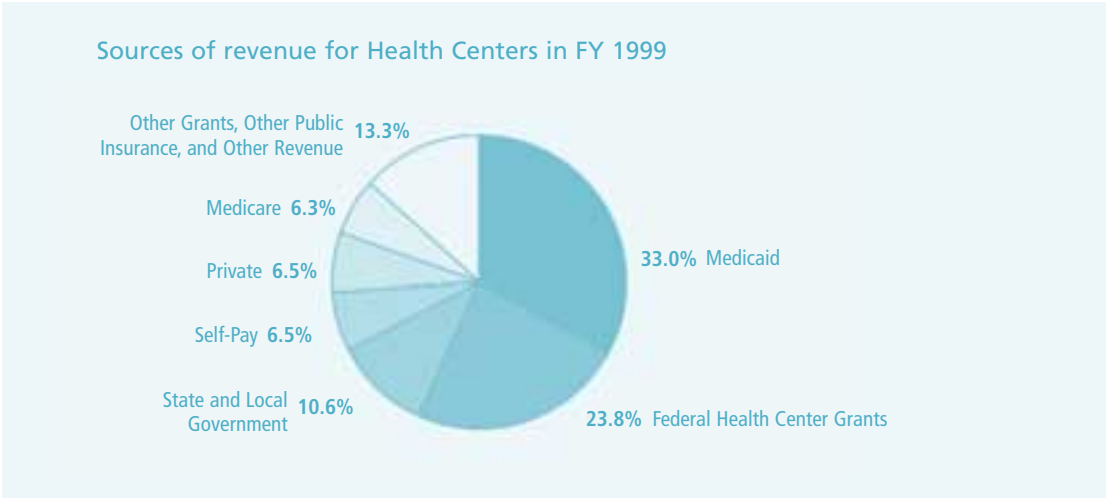
Clinics funded through the Community Health Center Program have added more than 1 million new uninsured patients to their rolls in the past 3 years alone, according to the National Association of Community Health Centers. The proportion of uninsured patients at these centers is about four times greater than in a typical private practice and is growing because community hospitals and private physicians are providing less uncompensated care than in the past.

Organizations serving high numbers of the medically indigent do not have the privately insured patient base from which they can cover some of the costs of caring for the uninsured. Health Center grant dollars represent just 24 percent of total revenues for the average grantee, even though 41 percent of patients have no insurance. Therefore, these organizations are providing care for which they receive no reimbursement.

CHALLENGE NO. 2: REDUCTIONS IN MEDICAID REIMBURSEMENTS

Health Centers depend on a variety of income streams. Reimbursements from Medicaid are the largest source, providing 33 percent of total Health Center revenue. In contrast, a typical private practice receives 9 percent of its funding from Medicaid.[7] Given Medicaid's role in financing Health Centers, they are vulnerable to reductions and fluctuations in Medicaid reimbursement.

The Balanced Budget Act of 1997 phased out a 1989 provision guaranteeing cost-based reimbursement from Medicaid to Federally Qualified Health Centers.* A moratorium on the phase-out was put



Source: Bureau of Primary Health Care (see note 3, chapter 2).

*Health Centers and other organizations that meet specific government requirements.

into effect with passage of the Balanced Budget Refinement Act of 1999. In some States, waivers to State Medicaid programs have led to reduced reimbursement rates for treating this population of health care clients. However, with the passage of the Medicare, Medicaid, and State Children's Health Insurance Programs Benefits Improvement and Protection Act of 2000, States are to pay Federally Qualified Health Centers using a prospective payment system that takes into account their previous year's costs, changes in the Medicare Economic Index, and growth or decline in scope of services. Thus, Health Centers should benefit from more stable Medicaid payments.

CHALLENGE NO. 3: PRIVATE HOSPITALS, SURGEONS, AND SPECIALISTS ARE TREATING FEWER INDIGENT PATIENTS

Health Centers, like all primary health care providers, sometimes need to refer patients for specialty care, hospitalization, and surgery. Lack of health insurance can complicate the referral process. Health Centers work hard to find hospitals and clinicians in private practice that will treat their patients; indeed, thousands of specialists have entered into referral relationships with Health Centers, at least on a limited basis.

But evidence indicates that these relationships are increasingly threatened.

MEMO—Received by a Community and Migrant Health Center
(names of facilities and clinicians omitted)

FROM: Division Head, GI, Tumor and Endocrine Division
Department of Surgery, University Health Center
TO: Health Clinic Director
DATE: February 4, 2000
SUBJECT: Surgery Scheduling

The Division of General, GI, Tumor and Endocrine Surgery has exceeded the limits of its ability to care for medically indigent patients, including those enrolled in the State's Indigent Care Program. Effective immediately, our office will cease scheduling clinic appointments for medically indigent patients who have "elective" or non-life-threatening conditions.

We regret that this action is necessary. Economic and manpower realities mandate that scarce health care resources allocated for these patients are devoted to those with truly acute or life-threatening problems.

Many factors put referral relationships at risk. Some Health Centers cite a public misperception that every community has a single provider designated to care for the indigent. Health Centers also report an eroding sense of responsibility for the indigent within the community at large. Additionally, the health care financing system in this country is in a state of flux, and the fallout has increased pressure on the bottom line for all providers. Indigent patients are paying the price.

CHALLENGE NO. 4: MILLIONS LIVE IN HEALTH PROFESSIONAL SHORTAGE AREAS

Almost 49 million Americans live in Health Professional Shortage Areas. The National Health Service Corps places health care professionals in many of these areas, but the total need far exceeds Federal resources.

Claude Earl Fox, MD, Administrator, Health Resources and Services Administration:

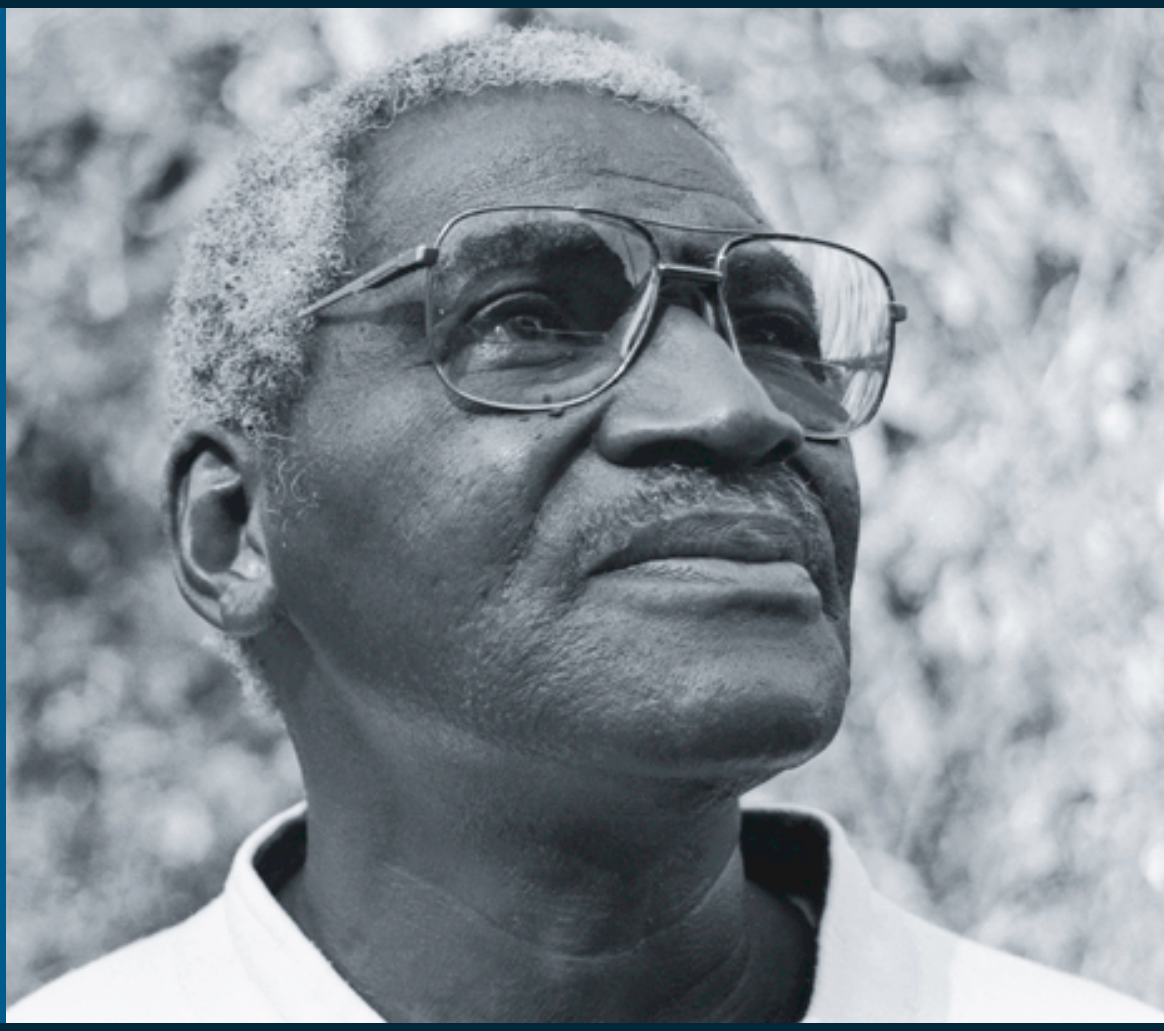
> Despite the fact that there is an oversupply of physicians in this country, there is also severe maldistribution. According to the Council on Graduate Medical Education, physicians are not being trained in the right specialties; physicians are not working in the right places; and physicians are not serving the populations with the greatest disparities in access and health status.

As of December 31, 2000, there were 2,787 Health Professional Shortage Areas for primary medical care, 1,233 for dental care, and 741 for mental health care.[8] The number of shortage areas dwarfs our ability to fill them with much-needed clinicians.

CHALLENGE NO. 5: POVERTY

Lack of insurance is just one of many factors affecting access to health care. Others include gender, geographic area of residence, sexual orientation, level of educational attainment, culture, language, and, of course, poverty. Poverty limits a patient's ability to pay for transportation to medical appointments and to pay for child care. It limits access to information about health care and programs that can help. Minorities, especially African-Americans and Latinos, bear far more than their share of poverty in the United States and, therefore, tend to be sicker than Caucasians.

"Before Tug River, there wasn't any place to see a doctor, whether you had health insurance or not."



CHAPTER 4. EMBRACING THE FUTURE

CHANGING LIVES CHANGING COMMUNITIES

OUR HEALTH ASSOCIATION employs 41 people—and that's a lot around here. Things have changed so much in the past 30 years.

My parents moved from Dechard, Tennessee, to find work in the Kentucky coal mines. Later, they came here to Gary, West Virginia, where I was born and have lived all my life. I retired from the mining industry in 1992 after 41 years on the job.

In the early 1970s, we didn't have a doctor in our area. I was on the board of the United Mine Workers, and I was asked to see what the union could do to help. The union president sent a couple of people down who had experience helping communities create clinics. We soon opened the Tug River Health Association, and we saw our first patient in April 1976. We got our first Community Health Center grant in July of that year. Now we receive funding from lots of other sources, too, like the Black Lung Program.

When we started, thousands of people were working in the mining industry. People had health insurance, but before Tug River, there wasn't any place to see a doctor, whether you had health insurance or not.

Today the situation is the other way around. Just 21 percent of our patients have health insurance through their jobs. Tug River has two full-time doctors, a physician's assistant, two nurse practitioners, two full-time dentists, and support staff. Because many of our patients are elderly and don't have cars, we also have a transportation program to get them to the clinic.

U.S. Steel shut down its last mines here in 1986. A few small mining companies are left, but they employ only 300 or 400 people. A lot of the towns around here look like ghost towns, because when the mining companies left, the family businesses that depended on them also closed down. It was a domino effect. Now many people work for fast-food restaurants or have telemarketing jobs, but they don't have any health benefits.

Francis Martin, Gary, West Virginia

CHAPTER 4

EMBRACING THE FUTURE

We are working to create a high-quality, culturally competent, community-based health care system that ensures access to primary health care for everyone—a system that includes prevention, early diagnosis and treatment, oral health, mental health, and substance abuse treatment. We are building a system whereby communities can implement solutions that respond to their unique needs, a system that empowers individuals to participate in their own health care.

Our goals are not modest. They can't be because so much unmet need still exists. And with 4,000 points of access across the country delivering state-of-the art health care, we are in a unique position to respond.

100 PERCENT ACCESS, 0 HEALTH DISPARITIES CAMPAIGN

Dr. Gaston:

> Government cannot single-handedly solve the health care crisis in the United States, and neither can corporate America or community leaders. But by pooling our resources—and that includes our creativity, not just our money—we can reach people who, without us, probably won't ever get any health care, except in a hospital emergency room.

Our goal is to ensure 100 percent access to health care and 0 health disparities. Our approach is to unite private industry, nonprofits, government, and communities on behalf of people not receiving health care.

Communities are unique, and they must continually reassess how their assets are being used to solve problems. Can a facility that lies idle in the evenings be used to serve people who cannot miss work to see a doctor during the day? Can health departments and Health Centers collaborate so that each does what it does best? Can an entrepreneur be persuaded to sit on a Health Center's board of directors so that the community may receive the benefits of ingenuity and creativity? Can communities of faith lead a health education campaign? When communities make possibilities like these a reality, more people receive health care, health disparities are reduced, costs are reduced, and the entire community benefits.

REALIZING OUR VISION

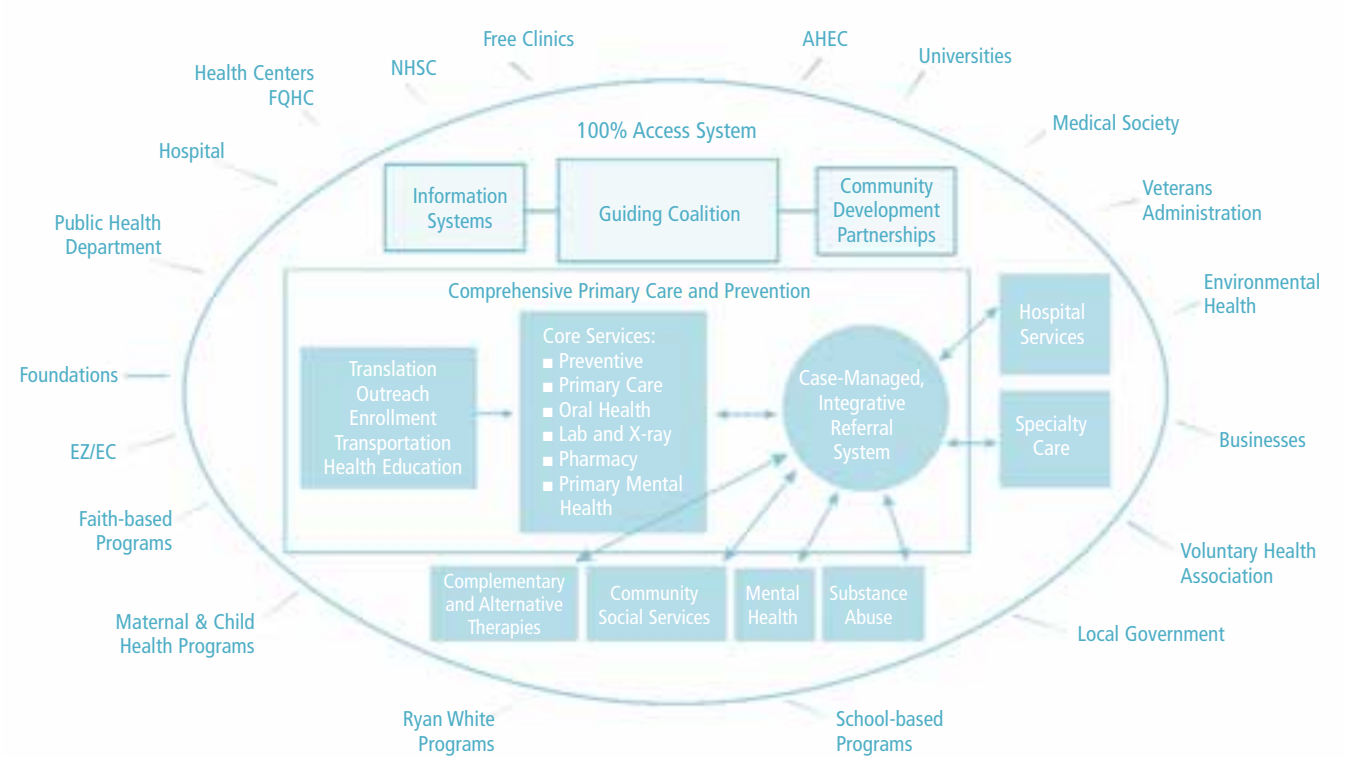
Reaching 100 percent access and 0 health disparities requires that the entire community—health care delivery entities, business, the faith community, schools, and the public health system—work in partnership to transform the health care landscape.

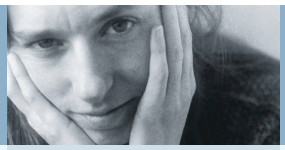
The Integrated Primary Care Community-Based Health System depicts a model of a comprehensive, system-wide approach built with primary care as the core. Communities that are working to achieve 100 percent access and 0 health disparities serve as models for other communities.

The optimal system puts into place health care improvements that we all seek. It includes standards that promote fairness, quality, and satisfaction. The vision focuses on "best" results for every member of the community. The new service delivery system envisions a series of coordinated encounters with members of a health care team, each performing a critical role.

Nonprofit State Primary Care Associations and Primary Care Offices (part of State health departments) are the voice of the underserved at the State level. They are integral to achieving 100 percent access to health care and 0 disparities in health status for all Americans.

THE INTEGRATED PRIMARY CARE COMMUNITY-BASED HEALTH SYSTEM





Cretta Johnson
Director
Hillsborough County
Health Care Plan:

"BETTER HEALTH
FOR MORE
PEOPLE WITH
LESS MONEY."

Marilyn Hughes
Gaston:

"IT CAN BE DONE.
WE SEE
COMMUNITIES
DOING IT.
IT'S THE
SMART THING
TO DO.
IT'S THE
RIGHT THING
TO DO."

REALIZING OUR VISION REQUIRES:

- Strengthening the safety net, expanding and integrating dental and mental health services into primary care, and expanding the National Health Service Corps' interdisciplinary approach to care;
- Expanding the systems of care to additional needy areas;
- Improving and expanding the work force and its diversity;
- Increasing excellence in medical practice by using outcomes to measure performance, affirming our commitment to continuous quality improvement, eliminating health care disparities among racial and ethnic minorities, and seeking outside validation, such as accreditation from the Joint Commission on Accreditation of Healthcare Organizations for 90 percent of our Health Centers.

APPENDICES

APPENDIX A: FY 2000 BUREAU OF PRIMARY HEALTH CARE GRANTS BY STATE AND U.S. TERRITORY

STATE	FUNDING	STATE	FUNDING
Alabama	$30,807,605	Missouri	$26,168,371
Alaska	$4,832,143	Montana	$5,769,731
Am. Samoa	$99,850	Nebraska	$2,270,758
Arizona	$17,786,291	Nevada	$5,411,132
Arkansas	$14,798,999	New Hampshire	$4,525,434
California	$79,680,024	New Jersey	$17,617,141
Colorado	$31,197,697	New Mexico	$20,825,555
Connecticut	$10,614,625	New York	$61,184,587
Delaware	$2,350,405	North Carolina	$24,825,630
Dist. Columbia	$12,998,707	North Dakota	$1,286,155
Florida	$55,598,687	Ohio	$30,068,336
Fed. States Micronesia	$142,362	Oklahoma	$6,041,067
Georgia	$22,820,011	Oregon	$12,981,768
Guam	$316,803	Pennsylvania	$33,709,457
Hawaii	$9,671,063	Puerto Rico	$32,613,771
Idaho	$8,117,630	Rep. of Palau	$532,403
Illinois	$35,900,168	Rhode Island	$6,450,045
Indiana	$9,527,021	South Carolina	$24,391,662
Iowa	$8,809,850	South Dakota	$4,864,702
Kansas	$4,349,941	Tennessee	$20,098,938
Kentucky	$15,724,753	Texas	$60,707,802
Louisiana	$12,945,567	Utah	$5,860,031
Maine	$6,519,483	Vermont	$1,699,127
Maryland	$15,041,684	Virgin Islands	$608,038
Marshall Islands	$286,824	Virginia	$17,729,694
Massachusetts	$28,169,263	Washington	$30,899,299
Michigan	$25,888,963	West Virginia	$16,891,674
Minnesota	$10,651,964	Wisconsin	$11,354,264
Mississippi	$28,703,960	Wyoming	$1,626,536
		TOTAL	$993,365,451

APPENDIX B: FY 2000 NATIONAL HEALTH SERVICE CORPS FIELD STRENGTH

STATE	NO. OF PEOPLE	STATE	NO. OF PEOPLE
Alabama	37	New Hampshire	7
Alaska	9	New Jersey	22
Arizona	67	New Mexico	57
Arkansas	15	New York	183
California	156	North Carolina	89
Colorado	47	North Dakota	9
Connecticut	39	Ohio	56
Delaware	4	Oklahoma	16
Florida	78	Oregon	36
Georgia	76	Pennsylvania	96
Hawaii	3	Rhode Island	16
Idaho	25	South Carolina	49
Illinois	88	South Dakota	12
Indiana	29	Tennessee	43
Iowa	49	Texas	93
Kansas	31	Utah	66
Kentucky	31	Vermont	5
Louisiana	34	Virginia	31
Maine	44	Washington	83
Maryland	27	West Virginia	41
Massachusetts	59	Wisconsin	37
Michigan	146	Wyoming	21
Minnesota	46		
Mississippi	21	District of Columbia	20
Missouri	58	Guam	1
Montana	15	Pacific Basin	5
Nebraska	17	Puerto Rico	21
Nevada	8	Virgin Islands	2
		TOTAL	2,376

APPENDIX C: NOTES

CHAPTER 1

[1]Bureau of Primary Health Care, *Uniform Data System National Summary Data, 1999.* Report prepared for the Bureau of Primary Health Care by JSI (John Snow, Inc.). Bethesda, MD, October 2000.

[2]U.S. Census Bureau, Press Release, September 28, 2000, www.census.gov/Press Release/www/2000/ch00-160.html.

[3]National Center for Farmworker Health, www.ncfh.org/aboutfws.

[4]Bureau of Primary Health Care, *Bureau Common Reporting Requirements.* Bethesda, MD, Health Resources and Services Administration, 1990.

CHAPTER 2

[1]MDS Associates, *Evaluation of the Effectiveness and Impact of Community Health Centers; Content of Care for Four Conditions: Final Report.* HRSA Contract 240-94-0054. Bethesda, MD, Health Resources and Services Administration, 1999.

[2]Bureau of Primary Health Care, Office of Data, Evaluation, Analysis and Research, *Health Center User Visit Survey, 1995.* Bethesda, MD, Health Resources and Services Administration.

[3]Bureau of Primary Health Care, *Uniform Data System National Summary Data, 1999.* Report prepared for the Bureau of Primary Health Care by JSI (John Snow, Inc.). Bethesda, MD, October 2000.

[4]Regan, J., et al., "Cancer Screening Among Community Health Center Women: Eliminating the Gaps." *Journal of Ambulatory Care Management,* 22(4): 45-52, 1999.

[5]National Center for Health Statistics, *National Health Interview Survey, Healthy People 2000, 2010*. Centers for Disease Control, Hyattsville, MD, 1994

[6]Bureau of Primary Health Care, *Community Health Center User Survey.* Bethesda, MD, Health Resources and Services Administration, 1994.

[7]American Diabetes Association, "Diabetes Facts and Figures," www.diabetes.org/ada/facts.asp.

[8]American Lung Association, "Asthma Facts and Misconceptions,"www.lungusa.org/asthma/merck_misconcept.html.

[9]Samuels, M.E., et al., *Rural Community and Migrant Health Center Administrators' Educational Preparation, Attributes, and Management Beliefs.* Columbia, SC, University of South Carolina, April 1995.

[10]Samuels, M.E., et al., *Gaining a Better Understanding of Community and Migrant Health Center Board Chairs: A National Survey.* Columbia, SC, University of South Carolina, June 1999.

[11]Zuvekas, A., et al., "Measuring the Primary Care Experiences of Low-Income and Minority Patients." *The Journal of Ambulatory Care Management,* 22(4): 63-78, 1999.

[12]Falik, M., et al., *ACSC Experience by Usual Source of Health Care: Comparing Medicaid Beneficiaries Who Rely on CHCs With Medicaid Beneficiaries Who Rely on Other Primary Care Providers.* Draft Final Report. Bethesda, MD, Bureau of Primary Health Care, July 1998.

CHAPTER 3

[1]U.S. Census Bureau, Press Release, September 28, 2000, www.census.gov/Press Release/www/2000/ch00-160.html.

[2]Roetzheim et al., in: Kaiser Commission on Medicaid and the Uninsured, *Uninsured America, Key Facts*. Washington, DC, The Henry J. Kaiser Family Foundation, March 2000.

[3]Ayanian J.Z., et al., in: Kaiser Commission on Medicaid and the Uninsured, *Uninsured America, Key Facts*. Washington, DC, The Henry J. Kaiser Family Foundation, March 2000.

[4]Children's Defense Fund, "Key Facts About Uninsured Children," www.childrensdefense.org/health_keyfacts.html.

[5]Newacheck, P.W., et al., in: Kaiser Commission on Medicaid and the Uninsured, *Uninsured America, Key Facts*. Washington, DC, The Henry J. Kaiser Family Foundation, March 2000.

[6]Weissman, J.S., et al., in: Kaiser Commission on Medicaid and the Uninsured, *Uninsured America, Key Facts*. Washington, DC, The Henry J. Kaiser Family Foundation, March 2000.

[7]Kaiser Commission on Medicaid and the Uninsured, *Health Centers' Role as Safety Net Providers for Medicaid Patients and the Uninsured.* Washington, DC, The Henry J. Kaiser Foundation, February 2000.

[8]Steinbruckner, L., *Selected Statistics on Health Professional Shortage Areas as of December 31, 2000.* Bethesda, MD, Health Resources and Services Administration, Bureau of Primary Health Care, Division of Shortage Designation, January 2001.

PRODUCED BY

RICHARD SEATON, Impact Marketing and Communications, under HRSA Purchase Order No. 00-0326.

Design by SANDRA MACDONALD.

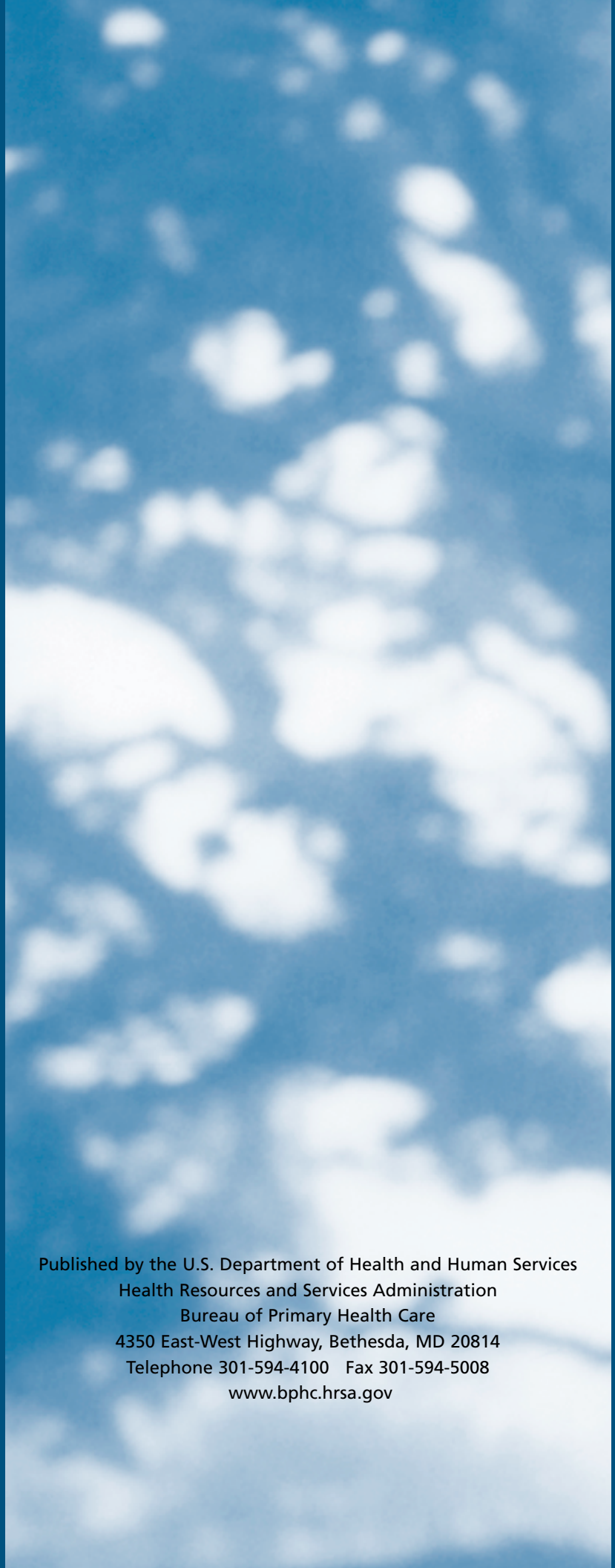
PHOTOGRAPHY

BEN FRASER, tree, cover and pages 3, 9, 15, 23, 29, and 33; and photograph, page 18.

LAURA MILLER, 3 photographs, left, front cover; 2 bottom photographs, back cover; and photographs, pages 7, 8, 10, 13, 14, 16, 21, 22, 27, and 28.

BENJAMIN TICE SMITH, photograph, page 20.

Printed on recycled paper.



Published by the U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Primary Health Care
4350 East-West Highway, Bethesda, MD 20814
Telephone 301-594-4100 Fax 301-594-5008
www.bphc.hrsa.gov